

Attention: Independent Radiology, Outpatient Hospitals and Physicians

Modifier 59

Modifier '59' (distinct procedural service) may now be utilized by radiology providers to identify a distinct service. When radiology services are performed, modifier '59' should be used to report procedures that are distinct or independent. Modifier '59' should not be used when a more descriptive modifier is available. The following are three different examples of appropriate billing of radiology codes with modifier '59':

Example 1

Diagnostic angiography (arteriogram/venogram) performed on the same date of service by the same provider as a percutaneous intravascular interventional procedure should be reported with modifier – 59. If a diagnostic angiogram (fluoroscopic or computed tomographic) was performed prior to the date of the percutaneous intravascular interventional procedure, a second diagnostic angiogram cannot be reported on the date of the percutaneous intravascular interventional procedure unless it is medically reasonable and necessary to repeat the study to further define the anatomy and pathology. Report the repeat angiogram with modifier – 59.

Example 2

CPT codes 76375 (76376, 76377 in 2006) (3-D rendering) are not separately reportable for nuclear medicine procedures (CPT codes 78000-78999). However, CPT code 76375 (76376, 76377 in 2006) may be separately reported with modifier – 59 on the same date of service as a nuclear medicine procedure if the 3D rendering procedure is performed in association with a third procedure (other than nuclear medicine) for which 3D rendering is appropriately reported.

Example 3

Radiation planning procedures may occasionally be repeated during a course of radiation treatment. Modifier -59 may be utilized to CPT code 77336 when the radiation planning procedure and continuing medical physics consultation occur on the same date of service.

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